VICTIM COMPENSATION BOARD
BC-VOC-0101 (REV. 3/01)

FOR BOARD USE ONLY

MENTAL HEALTH BILLING/VERIFICATION (B/V) FORM

VOC CLAIM NUMBER	**THIS FORM MUST BE COMPLETED FULLY AND SHOULD BE SUBMITTED WITHIN 30 DAYS OF THE DATE OF TREATMENT**	

SUBMISSION OF THIS BILL DOES NOT ENSURE IT WILL BE PAID. PAYMENT OR PARTIAL PAYMENT OF THIS BILL DOES NOT GUARANTEE THAT OTHER BILLS WILL BE PAID.

NAME OF PROVIDER ORGANIZATION OR FACILITY (IF APPLICABLE)	☐ FOR PROFIT	☐ NONPROFIT
NAME OF TREATING THERAPIST	LICENSE/REGISTRATION NO. (include prefix)	EFFECTIVE/EXPIRATION DATE

TREATING THERAPIST'S LICENSE TYPE: ☐ MFT ☐ MFT INTERN ☐ LCSW ☐ ASSOCIATE MSW

☐ PSYCHIATRIST ☐ PSYCH. ASSISTANT ☐ LICENSED CLINICAL PSYCHOLOGIST ☐ OTHER (PLEASE SPECIFY) ____________________

NAME AND TITLE OF SUPERVISING THERAPIST (FOR INTERNS)	SUPERVISOR'S LICENSE NUMBER (include prefix)	EFFECTIVE/EXPIRATION DATE OF SUPERVISING THERAPIST'S LICENSE

IF AUTHORIZED, PAYMENT SHOULD BE ISSUED TO: ☐ ORGANIZATION ☐ TREATING THERAPIST ☐ SUPERVISING THERAPIST

PAYEE'S TAX IDENTIFICATION NO.: SSN [ ] ________________ OR EIN [ ] ________________

MAILING ADDRESS OF PAYEE (Including city, state, and zip code)	IS THIS A NEW ADDRESS? ☐ YES ☐ NO	TELEPHONE (Include area code)

DATES OF SERVICE	DESCRIPTION OF SERVICE INDIVIDUAL	GROUP	FAMILY	(SPECIFY OTHER)	PROCEDURE CODE	SESSION LENGTH	BILLED AMOUNT
	☐	☐	☐	☐			
	☐	☐	☐	☐			
	☐	☐	☐	☐			
	☐	☐	☐	☐			
	☐	☐	☐	☐			

PERCENTAGE OF TREATMENT NECESSARY AS A DIRECT RESULT OF THE QUALIFYING CRIME: LESS THAN & INCLUDING 50% ☐ MORE THAN 50% ☐ 100% ☐	TOTAL CHARGES FOR THIS BILL

AMOUNT PAID BY CLAIMANT	DOES CLAIMANT HAVE INSURANCE? YES ☐ NO ☐	NAME & TELEPHONE NO.OF INS. COMPANY (IF AVAILABLE, PLEASE PROVIDE COPIES OF EXPLANATION OF BENEFITS).	HOW WAS CLAIMANT REFERRED? ☐ County Mental Health Plan (Medi-Cal) ☐ Victim Witness ☐ Other (Please specify)

AMOUNT WRITTEN OFF	AMOUNT PAID BY OTHER	IF PAID BY OTHER, WHO MADE THE PAYMENT?

PROVIDER DECLARATION: I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form, and to the best of my information and belief, all my answers are true, correct, and complete, and; (2) all treatment noted on this bill (including attachments) was necessary as a direct result of the crime described on the patient's original Application for Crime Victim Compensation. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12651 for filing a false claim with the State of California and may also be guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).
If the claimant did not sign below, I certify that these services were provided to ( ) a minor or ( ) an adult victim and that every effort to locate the responsible adult has been made to no avail.

________________________ ________ ________________________ ________
THERAPIST'S SIGNATURE DATE SUPERVISING THERAPIST'S SIGNATURE DATE

TO BE COMPLETED BY CLAIMANT

CLAIMANT NAME (First, middle initial, last)	SOCIAL SECURITY NO.	DATE OF BIRTH	PHONE NO. (Work/home)

MAILING ADDRESS (city, state, and zip code)	IS THIS A NEW ADDRESS? YES [ ] NO [ ]

CLAIMANT DECLARATION: I declare under penalty of perjury that I received the services listed on the date(s) indicated, that all treatment sessions for this bill are direct result of the qualifying crime described on my original Crime Victim Compensation Application and that I have signed this bill only after the services were provided.

____ ________________
CLAIMANT'S SIGNATURE (Parent or Guardian's Signature if Patient is under age 18) DATE

MENTAL HEALTH
BILLING/VERIFICATION (B/V) ATTACHMENT FORM

CALIFORNIA VICTIM
COMPENSATION BOARD
BC-VOC-O101 (REV. 2/01)

PAGE _____ OF _____

FOR BOARD USE ONLY

VOC CLAIM NUMBER

DATES OF SERVICE	(11) DESCRIPTION OF SERVICE (INDIVIDUAL, GROUP, FAMILY, OTHER)				PROCEDURE CODE	SESSION LENGTH	BILLED AMOUNT
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			
	☐ IND	☐ GRP	☐ FAM	☐ OTHER			

INSTRUCTIONS FOR COMPLETING BILLING/VERIFICATION (B/V) FORM

The form on the reverse side is the Mental Health Billing Verification (B/V) Form. It was designed for mental health providers to submit outpatient mental health counseling expenses to the California Victim Compensation Board (Board), which administers the Victims of Crime Program (Program). Board staff uses information on the form to verify expenses for payment. The form MUST be fully completed for payment to be considered. Incomplete forms will delay payment. Services billed on this form may be reimbursed when:

- The claim has been found eligible by the Board;
- Services are provided by therapists who are licensed or otherwise authorized to receive reimbursements from the Program; and
- Board staff has verified the percentage of treatment necessary as a direct result of the qualifying crime.

When completing this form, please be advised:

- **The submission of this form does not guarantee payment by the Board**.
- The adult patient or legal guardian of a minor patient is ultimately responsible for any expenses incurred.
- All available sources of reimbursement must be billed first.
- A separate B/V Form must be submitted for each qualifying direct or derivative victim receiving individual counseling. Family sessions involving the direct victim should be included on billing statements for the direct victim.

TREATING THERAPIST INFORMATION – The name of the actual treating therapist, whether a licensed therapist or a registered intern, must be listed in the “Name of Treating Therapist” section. Information on the therapist supervising an intern who provides treatment must be listed in the “Supervising Therapist” section.

TOTAL CHARGES – DO NOT include balance forward information.

PROVIDER/PATIENT DECLARATION –These sections must be signed by the appropriate parties.

WHO COMPLETES THE B/V FORM – The provider is responsible for completing and signing the form under the “Provider Declaration” statement. The B/V Form should be submitted once a month, unless treatment has terminated.

WHERE TO SUBMIT THE B/V FORM – Submit the form to the California Victim Compensation Board at: P.O. Box 942003, Sacramento, CA 94204-2003. If a local Victim Witness Center (VWC) is processing the claim, submit the form directly to the VWC verification unit. In order to obtain status on a claim you may call the Board’s toll-free number 1-800-777-9229 or ask the patient.

WHERE CAN MORE B/V FORMS BE OBTAINED AND WHERE TO CALL WITH QUESTIONS: – If original BV forms are needed, or for specific questions on completing the form on existing claims, providers may call the Board toll-free at 1-800-777-9229. Blank copies of this form should be copied on green paper. If the form is copied, we will accept only original signatures. You may visit our website at http://www.boc.ca.gov for any additional information and forms.